Report to the General Court:

Payments for Prescribed Drugs

Commonwealth of Masssachusetts

April 1, 2004

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I. Executive Summary

This report is submitted pursuant to Outside Section 674 of Chapter 26 of the Acts of 2003 (the FY04 Budget), which required the Division of Health Care Finance and Policy (DHCFP) to conduct a study "on determining the rate of payment for those pharmacies that dispense prescribed drugs to nursing homes, assisted living facilities, hospice programs and similar institutional sites of care, those pharmacies that dispense sterile intravenous drugs ordered by physicians to patients in their homes, and all other pharmacies."

This report summarizes the current status of MassHealth rate payments for pharmacies, and provides a general update on the status of various pharmacy initiatives. In the course of our analysis, the DHCFP reviewed the implementation status of recent state legislative requirements affecting pharmacies, and evaluated MassHealth pharmacy access and reimbursement. The DHCFP also reviewed the financial condition of the long-term care pharmacy industry, evaluated a number of recent federal and state initiatives that could affect pharmacies throughout the Commonwealth, and evaluated other states' Medicaid pharmacy reimbursement formulas. Based upon our analysis to date, the DHCFP believes the current payment methodology is sufficient to ensure access to pharmacy services for MassHealth beneficiaries.

II. Status of FY04 Legislative Requirements

The FY04 budget contained several provisions that addressed MassHealth pharmacy payments and pharmacy licensure.

Outside Section 306

The FY04 Budget included the following language in Outside Section 306:

SECTION 306. Chapter 112 of the General Laws is hereby amended by inserting after section 39B the following section:

Section 39C. The board may, upon application, made in such manner and form as it shall determine, register an establishment for transacting business as a long-term care pharmacy or home fusionist pharmacy, and issue to such entity as it deems qualified to conduct long-term care pharmacy or home fusionist, a permit to operate. The board may deny such registration and refuse to issue such permit, if, in its reasonable discretion, such entity would be inconsistent with or opposed to the best interests of the public health, welfare or safety, but no such registration shall be made or permit issued in the case of a corporation, as defined in section 30 of chapter 63 and most recently amended by section 9 of chapter 300 of the acts of 2002, unless it shall appear to the satisfaction of the board that the management of such entity is controlled solely by a registered pharmacist. Such permit shall expire on December 31 of each uneven numbered year following the date of its issue, and the fee therefore, shall be determined annually by the commissioner of administration under the provision of section 3B of chapter 7. The board, in consultation with the department of public health shall promulgate regulations pertaining to the operation of long-term care and home fusionist pharmacies in the commonwealth subject to the provisions of section 2 of chapter 30A. Said board shall determine which regulations, applicable to a retail drug business under section 39 shall apply to long-term care or home fusionist pharmacies. The board shall, within 150 days after the filing of an application, render a final decision denying or allowing registration. Failure to render such decision, except when such failure to act is caused by the delay of the applicant, shall constitute an approval of the application and permit shall be issued. For the purposes of this section, the term long-term care pharmacy shall mean a pharmacy which dispenses pharmaceuticals, sterile intravenous drugs and nutritional products ordered by physicians to patients in nursing homes, assisted living facilities, hospice programs and similar institutional sites of care. For the purposes of this section, the term home fusionist pharmacy shall

mean a pharmacy which dispenses sterile intravenous drugs ordered by physicians to patients in their homes.

Currently, "long-term care" and "home fusionist" pharmacies are licensed by the Massachusetts Division of Health Professions Licensure's Board of Registration in Pharmacy under the category "Drug Store Permit."[1] This is the same licensure category under which most other pharmacies—such as CVS, Brooks, Walgreens, and independent pharmacies—are classified. Prior to the FY04 budget, there was no authority for a licensure distinction between "long-term care," "home fusionist" and all other retail pharmacies. Although "long-term care pharmacies" may choose to focus all of their business on filling nursing facility prescriptions, they are required to meet *all* Board of Pharmacy regulations, including accessibility to the general public, unless a waiver(s) has been granted by the Board.

The Board of Pharmacy has, however, maintained a formal process that allows for any licensed pharmacy to "petition for a waiver" of certain regulatory requirements. Upon approval, the Board of Pharmacy will issue a "special or limited-use permit" that would waive requested regulatory requirements (such as restricting operations to focus solely on the nursing home population). To date, however, no "long-term care" pharmacies have requested or been granted such a waiver.[2]

Outside Section 306 of the FY04 budget allows (but does not require) the Board of Pharmacy to "register an establishment for transacting business as a long-term care pharmacy or home fusionist pharmacy" and to issue them "permit[s] to operate." Last year, Chapter 13 Section 22 was added to M.G.L. and increased the membership of the Board of Pharmacy from 7 to 11 members. The legislation directs the additional 4 members to include: (1) a "long-term care" pharmacist; (2) a representative from the general public; (3) a physician; and (4) a nurse. However, to date a "long-term care" pharmacist has not been appointed. As a result, the Board has not issued any regulations implementing Outside Section 306, nor has it issued any such registrations or permits. In addition, no pharmacies have requested or applied, either formally or informally, for this separate registration.[3]

Finally, *any* MassHealth pharmacy provider may provide pharmacy services to MassHealth members in nursing facilities. As of November 2003, 281 separate general pharmacies participating in the MassHealth program provided services to MassHealth members in nursing facilities.[4] This represents over 25 percent of MassHealth provider pharmacies.

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[1] Retail pharmacies with a "Drug Store Permit" must also obtain a "Controlled Substance" license. Other categories of licensure include "Controlled Substance: Hospital/Clinic," "Nuclear Controlled Substance," "Nuclear Pharmacy," and "Certificate of Fitness." A "Certificate of Fitness" is also issued to allow a pharmacy or pharmacy department to use alcohol for the manufacture of U.S. Pharmacopoeia or National Formulary preparations and all medicinal preparations unfit for beverage purposes, and to sell alcohol as authorized under M.G.L. c. 138.

[2] Massachusetts Board of Registration in Pharmacy.

[3] Ibid.

[4] Per MassHealth billing records.

Outside Sections 326 & 327

> The FY04 Budget included the following language in Outside Sections 326 and 327:
>
> SECTION 326. The last paragraph of section 25 of said chapter 118E of the General Laws, as amended by said section 98 of said chapter 184 of the acts of 2002, is hereby further amended by striking out the last sentence and inserting in place thereof the following sentence: The division may also require, to the extent permitted by federal law, that recipients be liable for a copayment of up to $3 for all other covered services with the exception of mental health and substance abuse services. The division shall establish a per member out-of-pocket cap for all copayments.
>
> SECTION 327. The second sentence of the last paragraph of section 25 of said chapter 118E, as so appearing, is hereby amended by striking out the figure "$2" and inserting in place thereof the following: up to $3.

Copayment amounts are paid by individual MassHealth beneficiaries, with certain exceptions, directly to pharmacies on a per-prescription basis. Certain populations, such as pregnant women and residents in skilled nursing facilities, are exempt from copayments. Unless an exemption applies, MassHealth reduces the reimbursement for each claim it pays to pharmacies by this copayment amount, leaving the pharmacies to collect the payments. However, it should be noted that pharmacies have publicly stated that MassHealth beneficiaries often do not pay their copayments, yet pursuant to federal law pharmacies cannot fail to dispense a prescription because of this lack of payment. Neither MassHealth nor the DHCFP has accurate data on pharmacy copayment collection rates.

Outside Sections 326 and 327 of the FY04 budget authorize MassHealth to increase the pharmacy copayment to "up to $3 for all other covered services with the exception of mental health and substance abuse services" and to establish MassHealth member out-of-pocket caps for all copayments. Accordingly, MassHealth has increased the copayment from $2.00 to $3.00 per brand prescription, but decreased the copayment from $2.00 to $1.00 per generic prescription. As authorized by the budget, MassHealth also created a $200 annual member copayment cap ($184 for the period February through December 2004).

Line Item 4100-0060 Appropriation Language

Dispensing fees are payments to pharmacies for the certain costs involved in dispensing prescribed drugs *other than* the acquisition cost of the pharmaceutical products. The MassHealth dispensing fee was $3.00 per prescription from February 1, 1995 through October 31, 2002. The DHCFP increased the dispensing fees to $3.50 for brand drugs and $5.00 for generic drugs effective November 1, 2002 through November 30, 2003. Line item 4100-0060 of Chapter 26 of the Acts of 2003 directed the DHCFP to reduce the dispensing fee in FY04, as follows:

> …notwithstanding any general or special law to the contrary said division shall set the rate paid for the dispensing fees to retail pharmacies for prescribed drugs to publicly aided or industrial accident patients at $3 beginning in fiscal year 2004.

Accordingly, the DHCFP reduced the dispensing fee for all prescriptions to $3.00 effective December 1, 2003. This budget language required the DHCFP to reduce the dispensing fee to all retail pharmacies currently subject to 114.3 CMR 31.00, including "long-term care" and "home fusionist" pharmacies, which remain licensed by the Board of Pharmacy as retail pharmacies.[5] A comparison to other states' Medicaid dispensing fees is addressed in Section IV on page 14.

[5] It should be noted that the Long-Term Care Pharmacy Alliance submitted a motion for preliminary injunction in Suffolk Superior Court, arguing that this legislatively required $3 dispensing fee was inadequate, and that the line item 4100-0060 language reducing the dispensing fee did not apply to "long-term care pharmacies" because the Legislature, via the Outside Section 306 language discussed above, authorized the Board of Pharmacy to create a distinct "long-term care pharmacy" registration process. On February 23, 2004 the court denied the plaintiff's motion for preliminary injunction. The Long-Term Care Pharmacy Alliance represents the four major national "long-term care" pharmacies: Kindred Pharmacy Services, Omnicare, NeighborCare, and PharMerica.

III. MassHealth Pharmacy Access

In this report, we evaluate "access" based on the following areas: MassHealth pharmacy spending, MassHealth pharmacy utilization, the MassHealth "drug list," and the geographic distribution of pharmacies throughout the Commonwealth.

Reimbursement History

The following provides a history of MassHealth pharmacy reimbursement methodology changes since 1995, as set forth in DHCFP regulation 114.3 CMR 31.00:

Timeframe	Ingredient Acquisition Payment	Dispensing Payment [6]
02/01/95 – 08/02/02	Lower-of: FULP [7], MULP [8], U&C [9] w/ 1% exclusion [10], or WAC [11] + 10%	$3.00 brand and generic
07/01/02 – current	No Change.	Added $5.00 Unit Dose Return Fee [12]
08/03/02 – 10/31/02	Lower-of: FULP, MULP, U&C w/out any exclusions, or WAC + 6%[13]	$3.00 brand and generic. No change to Unit Dose Return Fee.
11/01/02 – 11/30/03	No change.	$3.50 brand; $5.00 generic No change to Unit Dose Return Fee.

(Table continues on page 8)

[6] The dispensing fee is not paid when the acquisition payment is based on the pharmacy's Usual and Customary Charge (U&C), because the dispensing costs are already reflected in that amount.

[7] FULP is the Federal Upper Limit Payment for generic drugs. There is no FULP for brand drugs.

[8] MULP is the Massachusetts Upper Limit Payment for generic drugs. There is no MULP for brand drugs.

[9] U&C is the Usual and Customary Charge, or the lowest price accepted as payment by the pharmacy.

[10] If a provider could demonstrate that a particular contract represented less than 1% of its total prescription revenue, they could eliminate that contract from consideration in determining their lowest price, i.e. U&C.

[11] WAC is the Wholesaler's Acquisition Cost, a reference price reported by pharmaceutical manufacturers.

[12] This fee is paid to pharmacies for accepting returned (unused) drugs in unit-dose packaging, in accordance with MassHealth regulation 130 CMR 406.446.

[13] Changes made in response to Line Item 4100-0060 of Chapter 184 of the Acts of 2002 (the FY03 budget) which required the DHCFP to conduct a public hearing on MassHealth payment rates for prescribed drugs.

(Table continued from page 7)

Timeframe	Ingredient Acquisition Payment	Dispensing Payment [6]
04/01/03 – current (adopted and filed with State Secretary, but not implemented due to litigation) [14]	Lower-of: FULP, revised MULP[15], U&C w/out any exclusions, or WAC + 5%	No change.
12/01/03 – current	No change (see footnote 14).	$3.00 brand and generic No change to Unit Dose Return Fee.

Spending and Utilization Trends

MassHealth currently serves over 900,000 members, or over 15 percent of the Commonwealth's population. The FY04 MassHealth budget is approximately $6.45 billion, or nearly 30 percent of the entire state budget. Within the MassHealth budget, the fee-for-service (and primary care) pharmacy program spends approximately $1 billion in total state and federal funds, prior to rebates.

Total MassHealth pharmacy spending has increased dramatically in recent years, mainly due to the following three factors:

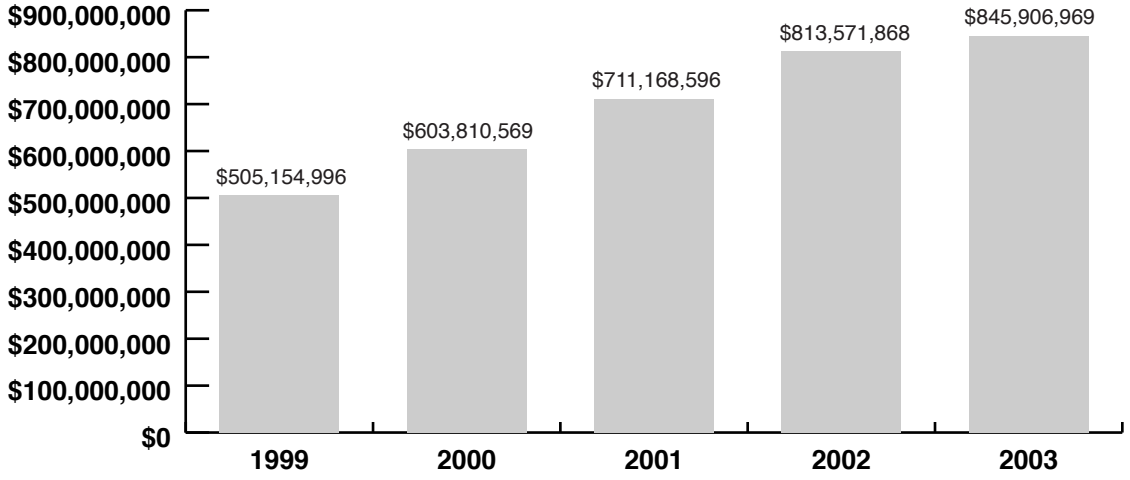
1. pharmaceutical manufacturer price increases
2. shifts in prescribing patterns from lower cost to higher cost drugs
3. increases in the total number of MassHealth prescriptions and average prescriptions per member

Non-institutional retail MassHealth pharmacy spending has increased from over $505 million in 1999 to nearly $846 million in 2003, or 67.5 percent. Non-institutional pharmacy claims have increased over 17 percent over this time period, while the number of MassHealth members receiving prescriptions has actually decreased. In other words, more Medicaid funds have been spent on a greater number of prescriptions for fewer MassHealth members.

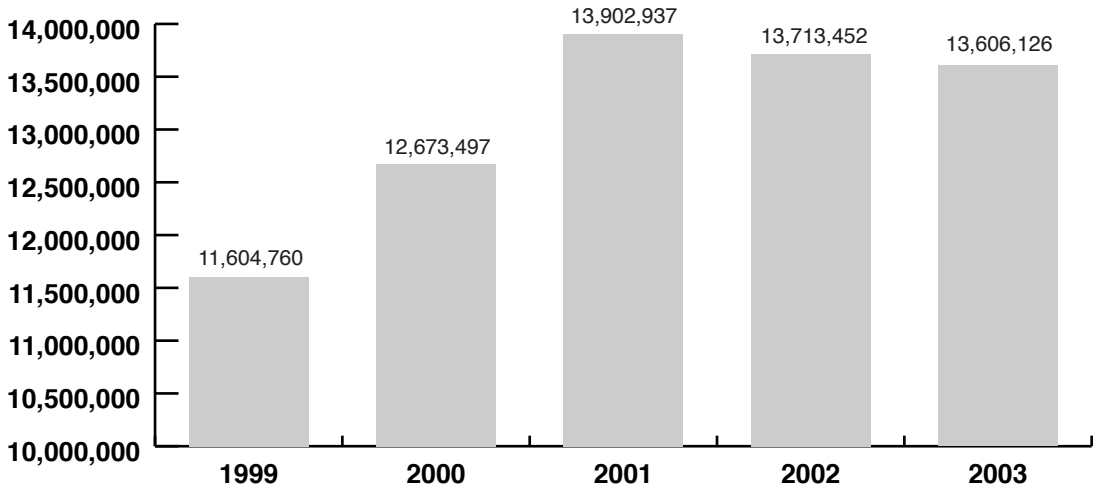
[14] Changes have not been implemented due to a federal district court order issued on April 1, 2003 arising from litigation initiated by the Long-Term Care Pharmacy Alliance. On March 17, 2004 the US Court of Appeals for the First Circuit vacated the preliminary injunction. MassHealth is continuing to pay pharmacy claims at the lower-of FULP, MULP, U&C w/out any exclusion, or WAC + 6% until the litigation is resolved.

[15] The MULP was revised by making the following three changes: (1) permitting any published or other public source of pricing, in addition to national price compendia such as First DataBank, to be the reference source to determine the published price of the least costly therapeutic equivalent; (2) reducing the upper limit from 150 percent to 130 percent of the published price of the least costly therapeutic equivalent; and (3) expanding applicability of the MULP to include drugs even when a FULP exists.

MassHealth Non-Institutional Pharmacy Spending
Aggregate Spending (including FFP, prior to manufacturer rebates)

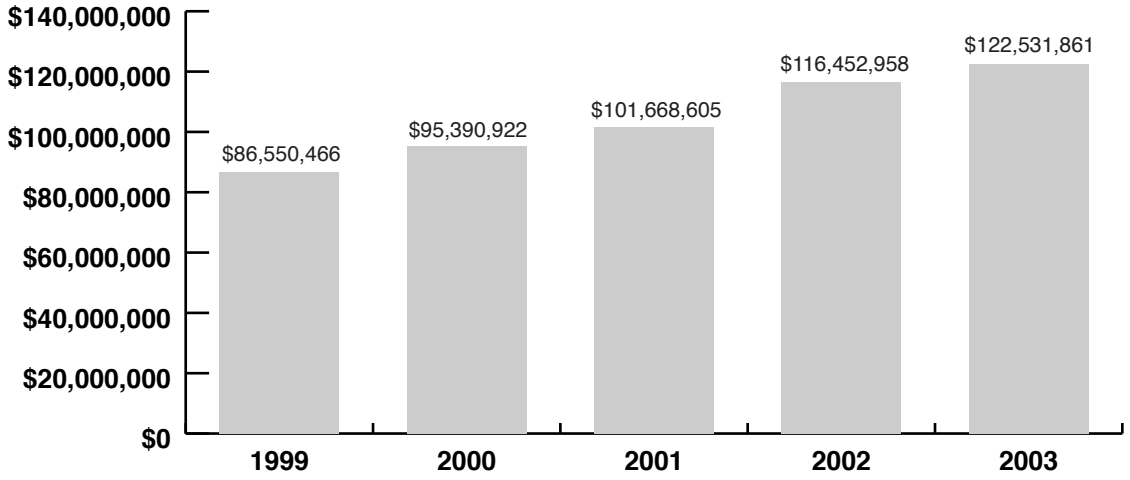


MassHealth Non-Institutional Pharmacy Claims

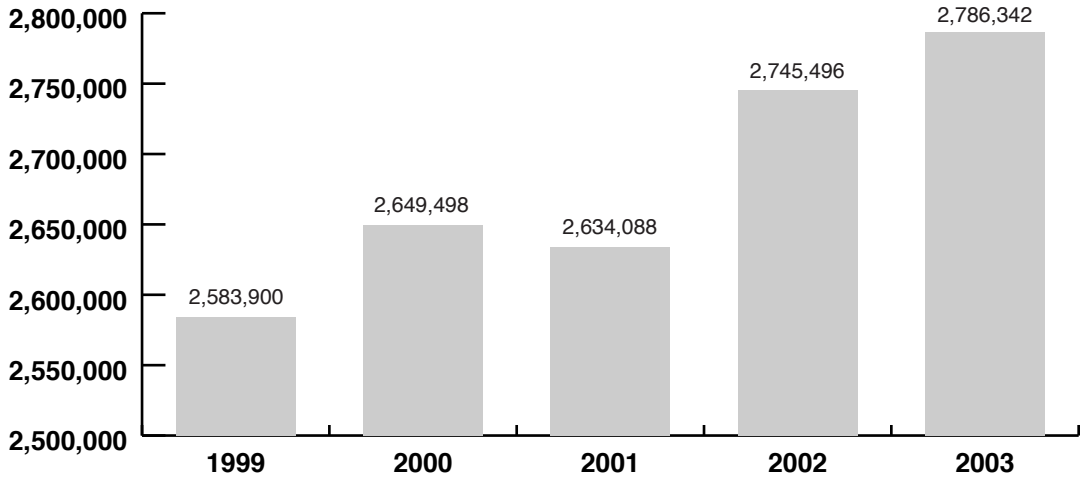


MassHealth spending on prescribed drugs in institutional long-term care settings (i.e. nursing homes) has increased from $86.5 million in 1999 to $122.5 million in 2003, or 41.6 percent. The number of long-term care pharmacy claims has increased nearly 8 percent over this time period, while the number of MassHealth members receiving prescriptions has decreased. As is the case with non-institutional pharmacy patterns, more Medicaid funds have been spent on a greater number of prescriptions for fewer MassHealth long-term care recipients.

MassHealth Institutional Long-Term Care Pharmacy Spending Aggregate Spending (including FFP, prior to manufacturer rebates)



MassHealth Institutional Long-Term Care Pharmacy Claims



MassHealth Drug List

The "MassHealth drug list" is a means by which to communicate prior authorization requirements for prescription drugs under the Massachusetts Medicaid pharmacy program. It is not a "preferred drug list" or a formulary *per se*. Rather, it is a list that indicates which drugs require

prior approval for MassHealth payment. The MassHealth drug list is addressed in this report in order to clarify its effect on access to prescribed drugs for MassHealth members.

In establishing the MassHealth drug list, pharmaceuticals are evaluated based on clinical efficacy, safety, and cost-effectiveness. MassHealth uses evidence-based clinical evaluation with several layers of review, when reviewing individual drugs. MassHealth conducted this process by therapeutic class, starting with high volume and high cost drug categories, and gave special consideration to vulnerable populations.

Requests for prior authorization must be submitted by the prescribing physician. MassHealth responds to all requests within 24 hours, and denied requests may be appealed. Based on the most recent data available from MassHealth, approximately 70 percent of all prior authorization requests were approved.

Through substituting less costly yet equally effective drugs where appropriate, the MassHealth drug list has contained the rate of growth of the average claim price since the program's inception, saving approximately $95 million in FY04 through cost avoidance. Most importantly, this has occurred *without* adversely affecting MassHealth access to necessary prescribed drugs.[16]

MassHealth Participation/Pharmacy Licensure Data

The DHCFP has monitored pharmacy participation in the MassHealth program. It is our understanding that no pharmacies have directly cited changes to MassHealth pharmacy reimbursement as the reason for either a withdrawal from the MassHealth program, or pharmacy closure.[17]

The maps on pages 12 and 13 illustrate the distribution of pharmacies with expired and current licenses. "Pharmacies" include all organizations issued a "Drug Store Permit" by the Board of Registration in Pharmacy, including long-term care pharmacies. The map on page 12 illustrates the geographic distribution of all pharmacies whose license expired within the past five years.[18] It is important to note, however, that an expired license does not necessarily mean that the pharmacy actually closed. For example, a pharmacy's relocation would require its license to expire, with the Board issuing a new license for the new location. Transfers of pharmacy ownership similarly result in expiration of licenses and issuance of new licenses.

The total number of expired pharmacy licenses within the past five years is 370, as shown in the table on page 12. However, the increase in 2002 is attributable to Brooks Pharmacy acquiring Osco Drug. When these 59 Osco Drug licenses that were transferred to Brooks Pharmacy are

[16] Per MassHealth Pharmacy Program.

[17] Per MassHealth Pharmacy Program and the Board of Registration in Pharmacy.

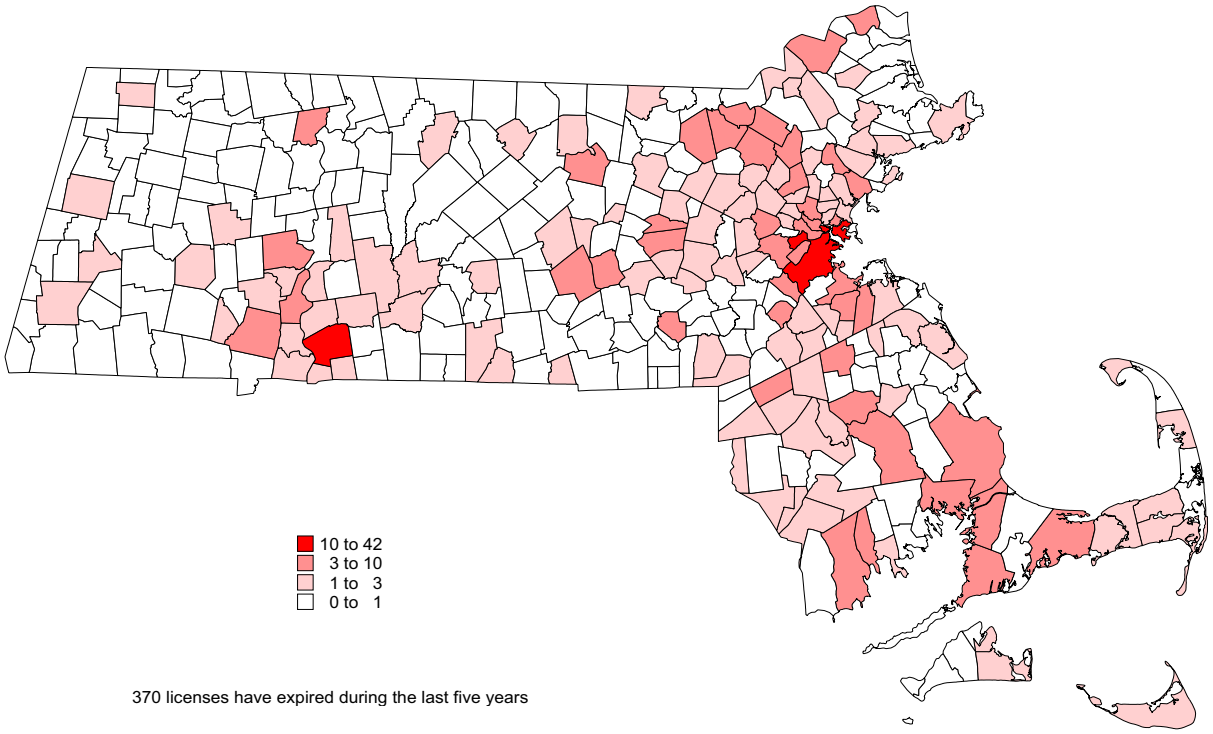
[18] Data from the Massachusetts Division of Professional Licensure, as of February 8, 2004.

omitted, the number of expired licenses in 2002 is reduced from 110 to 51. As mentioned above, however, an expired license does not mean that the pharmacy actually closed. Massachusetts pharmacy licensure data does not allow the determination of the precise number of actual number pharmacy closures. However, we believe that substantially fewer pharmacies have physically closed pharmacy operations than the total number of expired licenses suggests.

Number of Expired Licenses

1999	**82**
2000	**47**
2001	**65**
2002	**110**
2003	**66**
	370

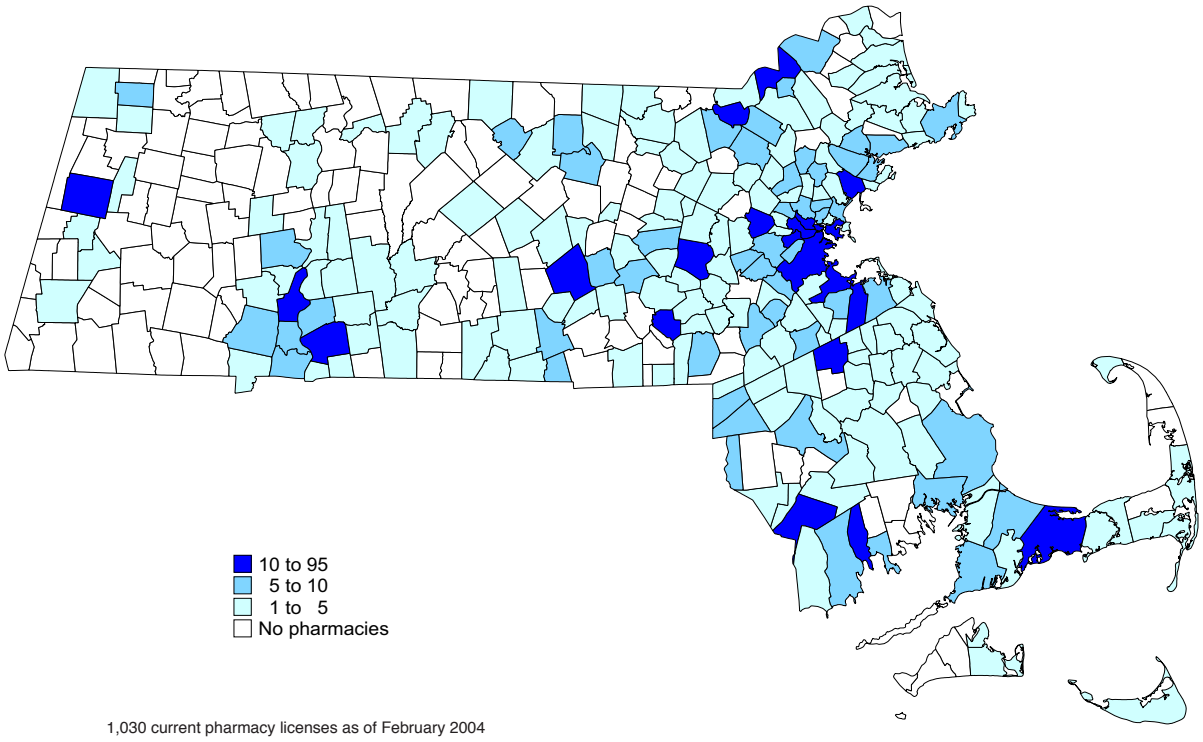
Total Number of Expired Pharmacy Licenses



[19] Data from the Massachusetts Division of Professional Licensure, as of February 8, 2004.

The map below illustrates the geographic distribution of all 1,030 pharmacies currently licensed.[19]

Number of Massachusetts Pharmacies by City and Town

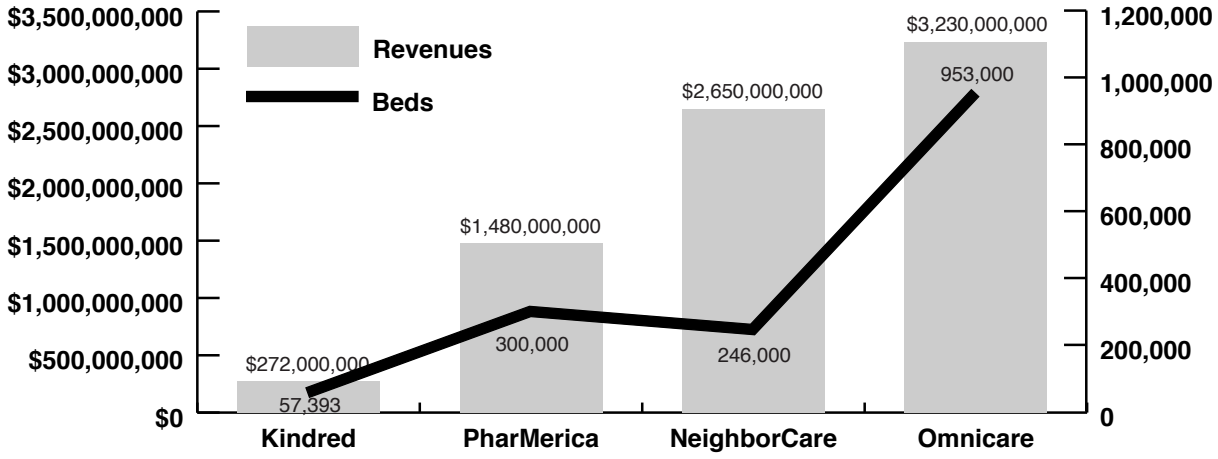


IV. Financial Review of "Long-Term Care Pharmacy" Industry

Currently, over 80% of the nursing home beds in the United States are served by "institutional" pharmacies that cater specifically to nursing homes and other facilities.

Four major national long-term care pharmacy companies (Kindred Pharmacy Services, Omnicare, NeighborCare, and PharMerica) serve more than 1.5 million people through networks of nearly 500 pharmacies nationwide. Total revenues of these four companies reached $7.6 billion in FY03.[20]

LTC Pharmacy Revenues and Beds Serviced, FY03



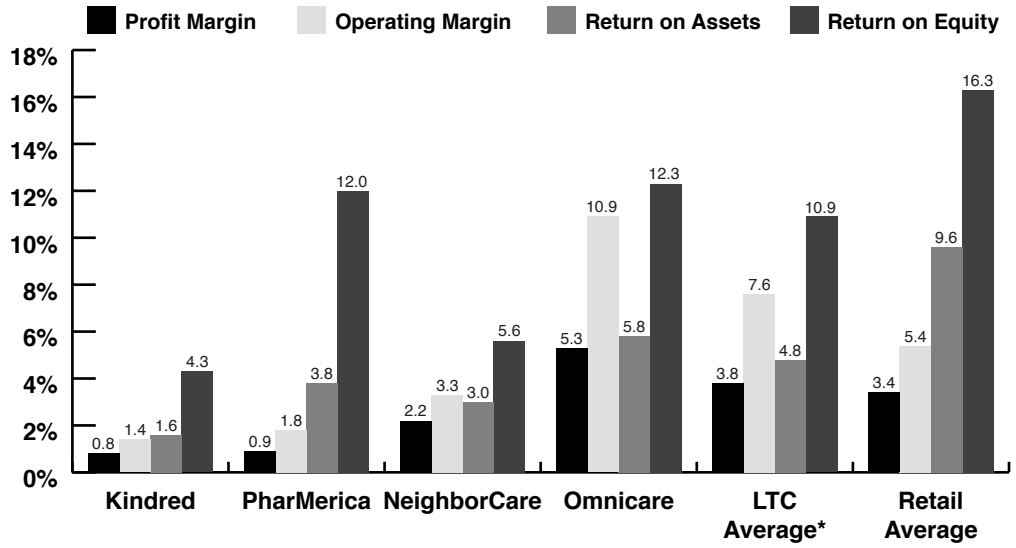
The overall financial status of the long-term care pharmacy industry is very good, which can be seen from four profitability measures: profit margin, operating margin, return on assets, and return on equity. The weighted average profit margin for the four companies in FY03 was 3.8%, higher than the traditional retail (non-long-term care) pharmacy (CVS and Walgreens) weighted average profit margin (3.4%) during the same period. This profit margin was also close to the average level (4.1%) of Fortune 500 companies over the period of 1991-2001 (see Pharmacy Financial Summary chart on page 16).

[20] "FY" is the corporation's fiscal year ending September 30, 2003.

The financial data of Kindred Pharmacy and PharMerica reflect the overall financial status of their parent companies (Kindred Healthcare and AmerisourceBergen), not just the long-term care pharmacy divisions. The profit margins of these two parent companies were lower than the other two long-term care pharmacy companies (Omnicare and NeighborCare). In the case of AmerisourceBergen, its major business line is drug wholesaling, which has very large volume. Therefore, its return on revenue (profit margin) tends to be lower than other companies mainly involved in long-term care pharmacy. The major business of Kindred Healthcare is its hospital division and health services division, not institutional pharmacy. Kindred Healthcare also just emerged from bankruptcy protection in 2001.

The weighted average operating margin of these four companies was 7.6% in FY03, much better than their total profit margin 3.8%. This operating margin was also much better than the 5.4% operating margin for the rest of the retail pharmacies in the same year.

LTC Pharmacy and Non-LTC Pharmacy Profitability, FY03



*Weighted by number of beds.

Considering the fact that the financial data of two companies include their parent companies in different business areas, the next two profitability measures (return on assets and return on equity) may be more reliable for making the comparison across companies. The weighted average return on assets and return on equity of these four companies were 4.8% and 10.9% in FY03.

The following chart summarizes the financial status of this industry as of 9/30/2003:

Pharmacy Financial Summary[21]						
Parent Company	Kindred Healthcare			Ameri-source-Bergen Corp	LTC Total $/ Average % [22]	Non-LTC (Chain) Total $/ Average % [23]
LTC Pharmacy	**Kindred Pharmacy**	**Omnicare**	**Neighbor-Care**	**PharMerica**		
Revenue (million$) Total Pharmacy	 $3,280 $272	 $3,230	 $2,650	 $50,580 $1,480[24]	 $7,632	 $59,220
Market Cap (million $)	$1,020	$4,430	$991	$6,310	$12,751	$50,990
Sales Growth Rate (3 years)	8.0%	12.2%	4.4%	62.1%	41.4%	13.1%
Beds	57,393	953,000	246,000	300,000	1,556,393	
Profitability Profit Margin Operating Margin Return on Assets Return on Equity	 0. 8% 1.4% 1.6% 4.3%	 5.3% 10.9% 5.8% 12.3%	 2.2% 3.3% 3.0% 5.6%	 0.9% 1. 8% 3.8% 12.0%	 3.8% 7.6% 4.8% 10.9%	 3.4% 5.4% 9.6% 16.3%

Company Specific Situation

Omnicare

Omnicare Senior Pharmacy Services is the nation's largest institutional pharmacy service provider. It serves long-term care facilities comprising more than 950,000 beds in 47 states, which

[21] Sources: company annual reports, and Yahoo! Finance company profile data. Except as specified, all the financial data are for parent companies. For purposes of this report, we have used the following definitions of terms:

Market Cap: The total dollar value of all outstanding shares. Computed as shares times current market prices. Capitalization is a measure of corporate size.

Profit Margin: Also known as Return on Sales, this value is the Net Income After Taxes for the trailing 12 months divided by Total Revenue for the same period and is expressed as a percentage.

Return on Assets: This value is the Income After Taxes for the trailing 12 months divided by the Average Total Assets, expressed as a percentage. Average Total Assets is calculated by adding the Total Assets for the 5 most recent quarters and dividing by 5.

Return on Equity: This value is the Income Available to Common Stockholders for the trailing 12 months divided by the Common Equity and is expressed as a percentage. Average Common Equity is calculated by adding the Common Equity for the 5 most recent quarters and dividing Average by 5.

[22] Weighted average by share of beds except for simple average of total compensation.

[23] Weighted average by total revenue except for simple average of total compensation. Data based on publicly available information for CVS and Walgreens. Brooks Pharmacy is privately owned by Canadian company Jean Coutu Group, Inc. Thus, the comparable data for Brooks Pharmacy are unavailable.

[24] For the fiscal year ended on September 30, 2002.

accounts for 61% of the total beds served by long-term care pharmacy industry. In January 2003, Omnicare completed an acquisition of NCS HealthCare (NCS) that was the fourth largest institutional pharmacy provider in the United States. Besides the pharmacy services, Omnicare has another smaller business segment, i.e. contract research organization services (CRO Services). CRO Services is an international provider of comprehensive product development and research services to client companies in the pharmaceutical, biotechnology, medical device and diagnostic industries, operating in 28 countries around the world. Omnicare was incorporated in 1981.

Omnicare achieved record sales, earnings and cash flow in 2002. Adjusted operating income totaled $295 million for the year 2002, up 20% from the comparable prior-year amount. Adjusted net income increased 28% to $140.3 million in 2002 and, on an adjusted diluted per share basis, reached $1.48, up 28%. This was achieved on a solid 21% increase in net sales to $2.6 billion for the year. Net cash flows from operating activities also reached an all-time record high of $211.4 million. These results were driven by new contract additions, increasing market penetration of newer drugs, sustained growth in the clinical programs and the addition of American Pharmaceutical Services, Inc. (APS).

PharMerica

PharMerica is a wholly owned subsidiary of AmerisourceBergen Corporation. The parent company is a global wholesale distributor of pharmaceuticals, medical-surgical supplies, specialty healthcare products, information management solutions and consulting services. The corporation was incorporated in 1988 and it was formed in connection with the merger of AmeriSource Health Corporation and Bergen Brunswig Corporation on August 29, 2001. The company's operating segments have been aggregated into two segments: Pharmaceutical Distribution and PharMerica. PharMerica is nation's second largest provider of institutional pharmacy products and services to patients in long-term care and alternate care settings. Its 125 regional pharmacies serve more than 300,000 beds in long-term care facilities, accounting for 19% of the total beds served by long-term care pharmacy industry.

PharMerica's operating revenue increased 9% for the fiscal year ended on September 30, 2002 to $1.48 billion compared to $1.35 billion in the prior fiscal year. This increase is principally attributable to growth in its workers' compensation business, which has grown at a faster rate than its long-term care business. Pharmerica's operating income of $83.5 million increased 21% compared to $68.9 million in the prior fiscal year. As a percentage of operating revenue, operating income was 5.66% in FY02, compared to 5.10% in the prior fiscal year.

NeighborCare

NeighborCare is the nation's third largest provider of institutional pharmacy services to long-term care facilities. The company provides pharmacy services for approximately 246,000 beds in long-term care facilities in 32 states and the Washington D.C., which accounts for 16% of the total beds served by long-term care pharmacy industry. On December 2, 2003, it changed its

name from Genesis Health Ventures, Inc. to NeighborCare, Inc. after it spun off its eldercare and rehabilitation business into a separately traded public company. Genesis Health Ventures, Inc. was originally incorporated in 1985. Approximately 91% of the company's institutional pharmacy revenues consisted of the sale of prescription and non-prescription pharmaceuticals.

NeighborCare's pro forma revenues for the year ended September 30, 2003 grew 7.5% to $1.3 billion versus $1.2 billion in the comparable period in the prior year. Of this growth, ($92.6 million), institutional pharmacy services revenue increased by approximately $72.9 million, or 6.9% over the same period in the prior year. The increase in revenue was primarily attributed to favorable changes in bed mix, higher patient acuity mix and drug trends. These factors have resulted in higher revenue per bed: $383.15 compared to $357.67 in the prior year.

Kindred Pharmacy Services

Kindred Pharmacy Services (KPS) is nation's fourth largest provider of pharmaceutical and resident care products to the senior care industry. It serves about 59,000 patients and residents of senior care facilities in 24 states, accounting for 4% of the total beds served by long-term care pharmacy industry. KPS became a separate division of Kindred Healthcare from early 2003, along with the Health Services Division and the Hospital Division. Kindred Healthcare, Inc., incorporated in 1998, provides long-term healthcare services primarily through the operation of nursing centers and hospitals. The company was formed from the spin-off of Ventas Inc.'s healthcare operations in May 1998. In September 1999, Kindred filed for bankruptcy protection. It emerged from the protection on April 20, 2001.

Revenues of KPS grew 12% in 2002 to almost $260 million. Operating income rose to $24 million in 2002, compared to $21 million in 2001 and $7 million in 2000.

V. Recent Federal and State Changes

Medicare Drug Benefit

The federal Medicare program was recently expanded to include a new drug benefit.[25] Beginning in the spring of 2004, Medicare drug discount cards will go into effect as a transition to the full expansion of a new Medicare Part D in 2006. The discount cards will provide discounts up to 25 percent off retail drug prices. The new Part D benefit is complicated. For the purposes of this report, we are limiting our analysis to the potential effects on pharmacies and the MassHealth program.

Enrollment in Part D will be voluntary. Those who choose to stay in traditional Medicare fee-for-service will receive their drug benefits through a prescription drug plan. Those who choose to enroll in a Medicare health maintenance organization (HMO) will receive their drug benefits through their HMO.

It is notable that the legislation does not allow the federal government (i.e. the federal Department of Health and Human Services) to use its purchasing power to negotiate lower prices from pharmaceutical manufacturers for the Medicare program. Rather, it will be left up to each individual prescription drug plan or HMO to negotiate drug prices independently. As a result, traditional retail pharmacies are concerned that they, rather than pharmaceutical manufacturers, will ultimately be the entities that will be forced to lower their prices (and accept reduced profit margins). However, it should be noted that pharmacies may also realize increased volume as a result of the new discount cards, which may partially offset reduced per prescription profits.

Individuals that are dually-eligible for both the Medicaid and Medicare programs and who currently receive drugs through Medicaid will lose their Medicaid drug coverage and instead receive their pharmacy benefit through the new Medicare Part D. States will be responsible for making certain payments back to the federal government for a portion of the drug expenditures for these dually-eligible beneficiaries. This amount will be based on each state's per capita spending on dually-eligible beneficiaries. The federal Department of Health and Human Services will notify states of their per capita amounts by the fall of 2005. At this time, it is unclear what the net fiscal impact of the Medicare drug benefit will be for the Commonwealth.

Automated Dispensing Systems

The federal Drug Enforcement Administration recently published proposed rules authorizing states to permit pharmacies to install and operate "automated dispensing systems" in nursing

[25] Public Law 108-173.

homes.[26] The purpose is to allow the latest technology to be used to prevent the accumulation of drugs that are dispensed by pharmacies, but not ultimately administered to nursing home residents. This can occur because drugs are typically dispensed in 30 day supplies, yet nursing home residents often need shorter supplies due to unanticipated changes in their medication regimen. These drugs represent waste within the health care delivery system, as well as potential opportunities for the diversion of controlled substances.

Automated dispensing systems offer an opportunity to better control drug inventory and to increase accountability and optimize safety. While MassHealth has implemented a return and re-use program for certain unused drugs that would otherwise be destroyed, to date it has been implemented on only a very limited number of unit-dose drugs. Further, MassHealth incurs a $5.00 cost per prescription to return the unused medication for future re-use. Automated dispensing systems, in contrast, could be much more extensive, and could be significantly more efficient by preventing waste in the front-end, rather than addressing the problem after-the-fact.

This program does have the potential to increase pharmacy costs in the short-run, due to the initial start-up investment costs of the automated dispensing system hardware. However, it could also result in significant long-term savings from decreased medication waste and greater efficiencies in dispensing drugs. To date the Board of Pharmacy has not issued regulations that will advise Massachusetts pharmacies in this matter.

S. 2158: Collaborate Drug Therapy Management

Senate bill number 2158 is a bill proposed in the Massachusetts legislature that authorizes the establishment of collaborative drug therapy management. It would allow pharmacists to expand their scope of practice by authorizing their collaboration with supervising physicians to provide "advanced pharmaceutical care to patients."[27] The expanded scope of practice would include drug therapy management, the ordering of laboratory tests, and the monitoring of outcomes of drug or device therapy of patients. Drug therapy management would include initiating, deleting, monitoring or modifying a patient's drug therapy, collecting patient histories, and obtaining vital signs. Currently 37 other states have enacted collaborative drug therapy management legislation. Under the Act, pharmacists would have the authority to enter into voluntary written collaborative practice agreements with supervising physicians in order to be authorized to engage in this practice, which would represent a significant expansion of pharmacists' current scope of service.

In the short-run, the establishment of collaborate drug therapy management could potentially result in an increase to pharmacies' (non-pharmaceutical acquisition) cost of providing services. However, in the long-run it could potentially reduce overall costs to the health care system, as

[26] Federal Register: November 3, 2003, Volume 68, Number 212.
[27] S. 2158 was referred to the Senate Ways and Means Subcommittee on November 24, 2003.

well as improve the quality of care, as drug therapies and costs become better managed among collaborating physicians and pharmacists.

Summary of Other State Medicaid Pharmacy Reimbursement Changes

Between 2000 and 2004, at least 33 states changed their Medicaid pharmacy reimbursement rates. Twenty-nine of those states (including Massachusetts) reduced either their dispensing fee and/or their ingredient reimbursement. Four more states added reimbursement incentives for generic drugs.

Institutional/Long-term-care Pharmacy Reimbursement Rates and Dispensing Fees
Nine states currently have a higher dispensing fee (or a capitated payment amount) for long-term care (LTC) or institutional pharmacies (however Maryland will eliminate theirs on July 1, 2004). This number is down from twelve because at least 3 states (Idaho, Kentucky and Florida) recently eliminated a higher dispensing fee for long-term care/institutional pharmacies (Kentucky's 2000 dispensing fee study found that LTC pharmacies had no greater cost than traditional pharmacies).

The following table summarizes other states' use of separate payment methodologies for long-term care pharmacies.

Long-term-care / Institutional Medicaid Pharmacy Reimbursement			
State	**LTC Add-On**	**LTC Add-on Recently Eliminated (All pharmacies now receive same rate)**	**Lower Ingredient Reimbursement Rate for "Specialty" (institutional, etc) Pharmacies**
California	✓		
Delaware			✓
Florida		✓	
Idaho		✓	
Kentucky		✓	
Maryland		✓ (will be eliminated as of July 1, 2004)	
Minnesota	✓		
Missouri	✓		
New Jersey	✓		
Oregon	✓		
South Dakota	✓		
Virginia	✓		
Wisconsin	✓		

The following provides more detail about two selected states, Delaware and Kentucky:

Delaware lowered the ingredient reimbursement rate for "specialty" pharmacies (including long-term-care and institutional pharmacies) to AWP[28]-16% (traditional pharmacies are reimbursed at AWP-14%). This reduction was based on the results of an audit, which concluded that long-term care/institutional pharmacies purchase drugs at better prices than traditional pharmacies. Both types of pharmacies receive the same dispensing fee ($3.65).

Kentucky's 2000 annual dispensing fee study performed by Myers and Stauffer LC found no association "between dispensing cost and unit-dose packaging or other measures of long-term-care dispensing activity; i.e., retail and long-term care pharmacies had similar average costs of dispensing." Therefore, Kentucky instituted the same dispensing fee ($4.51) for all pharmacies in January 2001. The study also revealed that dispensing IV solutions does cost more (Kentucky pays higher dispensing fees for IV solutions). However, they do not include dispensing fees for IV solutions when computing an average dispensing fee to pay to all pharmacies because approximately 95% of pharmacies would get an additional allowance for a service they were not providing and those pharmacies that were providing IV solutions would not be paid enough.

Survey of a Sample of States Regarding Medicaid Pharmacy Reimbursement
Staff at the DHCFP conducted a telephone survey of a sample of seventeen states in different regions of the country regarding their Medicaid pharmacy reimbursement structure. Due to nationwide state budget problems, most states (including Massachusetts) have been forced to limit funding for state programs, with many reducing pharmacy reimbursement for filling Medicaid prescriptions. Only a few states reduced their Medicaid pharmacy reimbursement rates based on results from formal studies or pharmacy audits. One mentioned basing their reduction on the federal Office of the Inspector General's (OIG) report on prescription drugs.

Only one state (Oregon) reported that one pharmacy stopped filling Medicaid prescriptions due to a copayment change; all other Medicaid pharmacy state contacts said that no pharmacies dropped out of the Medicaid program after the decrease in reimbursement.

[28] AWP is the Average Wholesale Price, a reference price reported by pharmaceutical manufacturers. Generally speaking, AWP -16% is roughly equivalent to WAC +5%.

The following table summarizes other states' recent changes to their pharmacy payment methodologies.

States Contacted Regarding Medicaid Pharmacy Reimbursement		
State	**Reduction in either Ingredient reimbursement or dispensing fee in last 4 years**	**Did pharmacies stop filling Medicaid prescriptions**
California	✓	No
Delaware	✓	No
Florida	See LTC pharmacy table	No
Idaho	✓	No
Kansas	✓	No
Kentucky	See LTC pharmacy table	No
Maine	✓	No
Maryland	✓	No
Minnesota	✓	No
Missouri	No	N/A
Montana	✓ (reduced ingredient reimbursement and increased dispensing fee at same time)	No
Nevada	✓	No
New Hampshire	✓	No
New York	✓	No
Oregon	✓	✓ (1 independent did stop, but due to copayment change)
Virginia	✓	No
Wisconsin	✓ (will be reduced further on 7/1/04)	No

The following provides more detail about two selected states, Maine and New Hampshire:

Maine's Governor recently proposed reducing the state's dispensing fee from $3.35 to $2.

New Hampshire has a "most favored nation" provision which requires that if a pharmacy participating in the Medicaid program accepts a reimbursement rate from a third-party payer that is lower than the Medicaid rate, the pharmacy must accept that lower rate for all Medicaid prescriptions. The state performed an audit that found at least one pharmacy selling prescription drugs at a rate four percent lower than what the state pays. The state lowered their rate for all pharmacies from AWP-12% plus a $2.50 dispensing fee to AWP-16% plus a $1.75 dispensing fee. This rate will be in effect for the first six months of 2004 at which time a permanent rate will be established.

VI. Conclusion

This report has summarized the current status of MassHealth rate payments for pharmacies and has provided a general update on the status of various pharmacy initiatives, as required by Outside Section 674 of Chapter 26 of the Acts of 2003 (the FY04 Budget).[29]

The DHCFP has concluded that the Commonwealth is in a similar situation compared to other states' Medicaid pharmacy programs. Massachusetts, like most other states, has implemented changes to the pharmacy payment methodology in recent years, and does not include differential payment for long-term care pharmacy services. Also like other states, it appears that few, if any, pharmacies have closed or withdrawn from the Medicaid program as a direct result of these payment changes.

Based on our analysis, the four national long-term care pharmacy chains appear to have very profitable operating margins. Our financial analysis of this for-profit industry does not lead us to conclude that long-term care pharmacies are in need of financial relief to ensure access for MassHealth members.

Finally, there are a number of current state and federal initiatives that will impact all retail pharmacy operations in the near future. The impacts on pharmacies, as well as the Commonwealth, of the recently enacted Medicare drug legislation, the recent federal authorization of automated dispensing systems in nursing homes, and proposed state legislation authorizing collaborative drug therapy management with pharmacists cannot be known at this time.

As a result, the DHCFP has determined that the current payment methodology is sufficient to ensure access to pharmacy services for MassHealth beneficiaries. We will continue to monitor pharmacy provider participation in the MassHealth program, as well as the impact of the initiatives described above, to ensure that MassHealth members continue to have access to these services in the future.

[29] This legislative mandate required the DHCFP to conduct a study "on determining the rate of payment for those pharmacies that dispense prescribed drugs to nursing homes, assisted living facilities, hospice programs and similar institutional sites of care, those pharmacies that dispense sterile intravenous drugs ordered by physicians to patients in their homes, and all other pharmacies." While the budget language references "those pharmacies that dispense sterile intravenous drugs ordered by physicians to patients in their homes," a lack of data in this area prevented the DHCFP from focusing on this subset of pharmacies.